*NOTE: This form is to be used **after** an inquest.*

| | **REGULATION 28 REPORT TO PREVENT FUTURE DEATHS**<br><br>**THIS REPORT IS BEING SENT TO:**<br><br>1. [redacted], Old Bridge Surgery, Looe |
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| 1 | **CORONER**<br><br>I am Andrew Cox, the Senior Coroner for the coroner area of Cornwall and the Isles of Scilly. |
| 2 | **CORONER'S LEGAL POWERS**<br><br>I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013. |
| 3 | **INVESTIGATION and INQUEST**<br>On 21/11/23, I concluded an inquest into the death of David John Lewsey who died on 15/12/22 at the age of 68.<br>.<br>The medical cause of death was recorded as:<br>1a) Pulmonary thromboembolism<br>1b) Deep vein thrombosis of left calf<br>1c) Knee replacement operation<br><br>I recorded a Narrative Conclusion that Mr Lewsey died from a known complication of an elective surgical procedure. |
| 4 | **CIRCUMSTANCES OF THE DEATH**<br>Mr Lewsey was a 68-year-old man who underwent a left knee replacement on 29/11/22. Upon discharge, he was prescribed with two weeks of aspirin to reduce the risk of developing a clot and codeine for pain relief. The codeine caused Mr Lewsey to become constipated.<br><br>On 15/12/22, he rang the surgery for treatment to relieve his constipation. In the first call with reception staff, he reported a 'terrible, terrible pain in his side.' This information was not passed on to the Advanced Nurse Practitioner (ANP) who returned Mr Lewsey's call.<br><br>In his first call with the ANP, Mr Lewsey said that his left side hurt like he had a stitch and that he felt pain when he breathed in. I found as fact that it was more likely than not that this was caused by a developing pulmonary embolus.<br><br>No consideration was given to excluding a PE as a possible cause of the |

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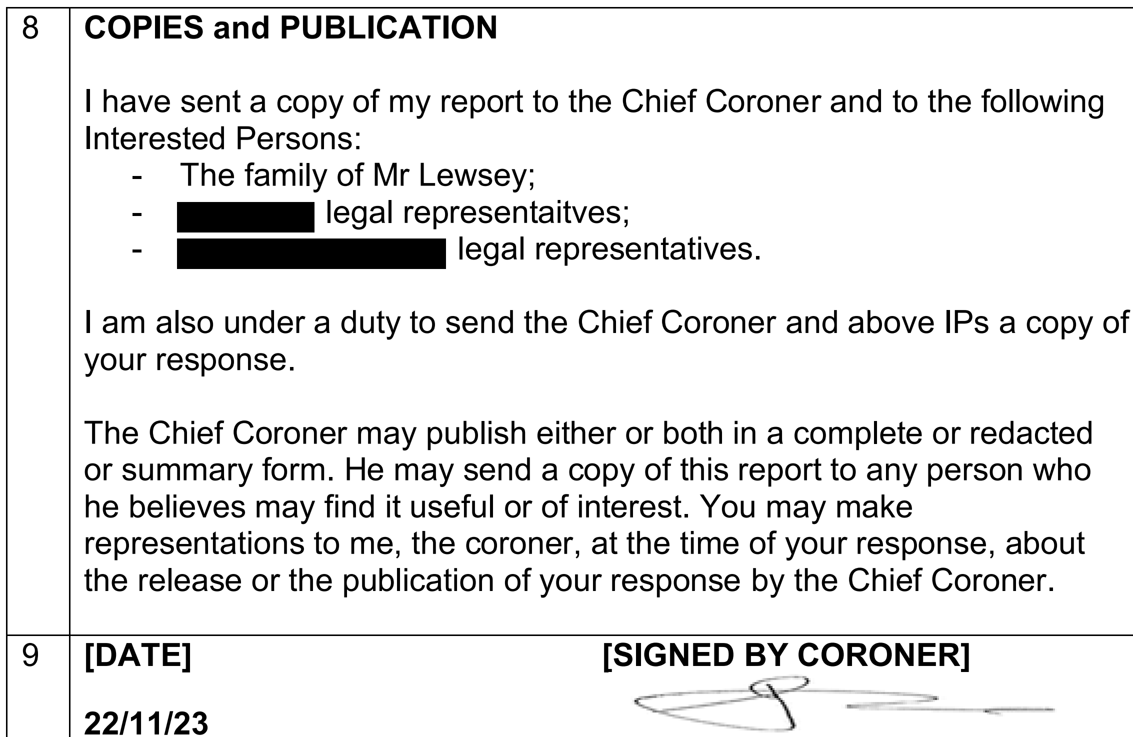
| | pain. It is more likely than not that the PE was caused by a DVT in his leg that developed following Mr Lewsey's immobility after his knee operation. Mr Lewsey collapsed later that evening at his home address and could not be resuscitated. |
| 5 | **CORONER'S CONCERNS**<br><br>During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths will occur unless action is taken. In the circumstances it is my statutory duty to report to you.<br><br>The **MATTERS OF CONCERN** are as follows:<br><br>- Evidence was heard at inquest that if the concern of a terrible pain in his side, reported in Mr Lewsy's first telephone call to reception staff, had been passed on to the ANP, the initial discussion between Mr Lewsey and the ANP may have started down a different path. It was recognised that the doctors and nurses dealing with duty calls work under pressure, and it was felt that ensuring accurate and complete information was passed to them may reduce that pressure and facilitate the provision of a better service to patients.<br>- The inquest also heard that reception staff had some training to raise a red flag if pain in the 'chest' was reported to them. Mr Lewsey said he had pain in his 'side' but the precise location of that pain was not explored further. While it was said in evidence that, typically, a PE will present with pleuritic or chest pain, it was noted that NICE guidance includes abdomen pain. You may wish to reflect on whether additional training is required for all staff on how to manage complaints of pain in the chest or abdomen particularly in patients who have recently undergone procedures that may have left them relatively immobile and at an increased risk of developing a DVT. |
| 6 | **ACTION SHOULD BE TAKEN**<br><br>In my opinion action should be taken to prevent future deaths and I believe you [AND/OR your organisation] have the power to take such action. |
| 7 | **YOUR RESPONSE**<br><br>You are under a duty to respond to this report within 56 days of the date of this report, namely by 19/1/24. I, the coroner, may extend the period.<br><br>Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise, you must explain why no action is proposed. |



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| 8 | **COPIES and PUBLICATION**<br><br>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons:<br>- The family of Mr Lewsey;<br>- ████ legal representaitves;<br>- ████ legal representatives.<br><br>I am also under a duty to send the Chief Coroner and above IPs a copy of your response.<br><br>The Chief Coroner may publish either or both in a complete or redacted or summary form. He may send a copy of this report to any person who he believes may find it useful or of interest. You may make representations to me, the coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner. |
| 9 | **[DATE]** **[SIGNED BY CORONER]**<br><br>**22/11/23** |